Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS487ASC	A. BUILDING _____ B. WING _____	01/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST MEDICAL ASSOC. AMB.	2450 W CHARLESTON BLVD LAS VEGAS, NV 89102

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 00	INITIAL COMMENTS Surveyor: 26855 This Statement of Deficiencies was generated as a result of a State Licensure focused survey conducted in your facility on 01/12/10 and finalized on 01/12/10, in accordance with Nevada Administrative Code, Chapter 449, Surgical Centers for Ambulatory Patients. A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following deficiencies were identified.	A 00		
A118 SS=E	NAC 449.9855 Personnel 3. A current and accurate personnel record for each employee of the center must be maintained at the center. The record must include, without limitation: (d) Such health records as are required by chapter 441A of NAC. This Regulation is not met as evidenced by: Surveyor: 26855	A118		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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A118	Continued From page 1 Based on interview and record review the facility failed to ensure 3 out of 10 employees had documented evidence in their health records of a pre-employment physical examination or certification from a licensed physician that the person was in a good state of health and free from active tuberculosis or any other communicable disease in a contagious stage. (Employees #1, #9, #10) Severity: 2 Scope: 2	A118		